

a hospital's validation score are eligible to be reconsidered.

(3) A hospital that is dissatisfied with a decision made by CMS on its reconsideration request may file an appeal with the Provider Reimbursement Review Board under part 405, subpart R, of this chapter.

[78 FR 75196, Dec. 10, 2013, as amended at 79 FR 67031, Nov. 10, 2014]

Subpart E—Updates

§ 419.50 Annual review.

(a) *General rule.* Not less often than annually, CMS reviews and updates groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

(b) *Consultation requirement.* CMS will consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise CMS concerning) the clinical integrity of the groups and weights. The panel may use data collected or developed by entities and organizations (other than the Department of Health and Human Services) in conducting the review.

(c) *Effective dates.* CMS conducts the first annual review under paragraph (a) of this section in 2001 for payments made in 2002.

Subpart F—Limitations on Review

§ 419.60 Limitations on administrative and judicial review.

There can be no administrative or judicial review under sections 1869 and 1878 of the Act or otherwise of the following:

(a) The development of the APC system, including—

- (1) Establishment of the groups and relative payment weights;
- (2) Wage adjustment factors;
- (3) Other adjustments; and
- (4) Methods for controlling unnecessary increases in volume.

(b) The calculation of base amounts described in section 1833(t)(3) of the Act.

(c) Periodic adjustments described in section 1833(t)(9) of the Act.

(d) The establishment of a separate conversion factor for hospitals described in section 1886(d)(1)(B)(v) of the Act.

(e) The determination of the fixed multiple, or a fixed dollar cutoff amount, the marginal cost of care, or applicable percentage under § 419.43(d) or the determination of insignificance of cost, the duration of the additional payments (consistent with subpart G of this part), the determination of initial and new categories under § 419.66, the portion of the Medicare hospital outpatient fee schedule amount associated with particular devices, drugs, or biologicals, and the application of any pro rata reduction under § 419.62(c).

[65 FR 18542, Apr. 7, 2000, as amended at 66 FR 55856, Nov. 2, 2001]

Subpart G—Transitional Pass-through Payments

SOURCE: 66 FR 55856, Nov. 2, 2001, unless otherwise noted.

§ 419.62 Transitional pass-through payments: General rules.

(a) *General.* CMS provides for additional payments under §§ 419.64 and 419.66 for certain innovative medical devices, drugs, and biologicals.

(b) *Budget neutrality.* CMS establishes the additional payments under §§ 419.64 and 419.66 in a budget neutral manner.

(c) *Uniform prospective reduction of pass-through payments.* (1) If CMS estimates before the beginning of a calendar year that the total amount of pass-through payments under §§ 419.64 and 419.66 for the year would exceed the applicable percentage (as described in paragraph (c)(2) of this section) of the total amount of Medicare payments under the outpatient prospective payment system, CMS will reduce, pro rata, the amount of each of the additional payments under §§ 419.64 and 419.66 for that year to ensure that the applicable percentage is not exceeded.

(2) The applicable percentages are as follows:

(i) For a year before CY 2004, the applicable percentage is 2.5 percent.